Admission/Visit Number _____

Arrival Date _____ | | | | | | | | |

Patient Name (Last, First, M) _____

UH MRN # _____

Date of Birth _____

UNIVERSITY OF MISSOURI HOSPITALS AND CLINICS
CONDITIONS OF SERVICE

I am signing as the patient seeking care, or as the parent, agent, guardian or responsible party of the patient named and in consideration for services rendered, agree, to the condition of service described here.

CONSENT AND AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I request and consent to health care services which may include tests, drugs, examinations, and other care ordered by my doctor(s) or a designee in order to provide medical care. Consent for standard and emergent hospital treatment and other routine medical screenings, stabilization and nursing procedures is hereby authorized, including but not limited to radiology, local anesthesia, laboratory tests, procedures, as well as intravenous and other modes of medication and nutritional administration and other care ordered specifically by a physician or customarily provided under medical supervision.

I acknowledge the University of Missouri Hospitals and Clinics (UMHC) Mission includes research and teaching, in addition to patient care and that medical and nursing care, while supervised by an attending physician, may be delivered by staff, consulting, and resident physicians; as well as nurses and other allied professionals. I understand that I may be approached regarding research which pertains to my condition and/or plan of care. I understand that I have the right to consent to participate in these research activities or to deny consent. I have been provided and understand the Patient Rights and Responsibilities as a patient of the UMHC.

I understand that University of Missouri Health care is not responsible for my health and safety if I choose to leave the hospital building.

CONFIDENTIALITY AND IDENTITY THEFT PROTECTION AND PREVENTION

I understand that certain events may be newsworthy and I agree that standard descriptions of my general condition (critical, serious, fair and good) may be released at the discretion of the UMHC to the news media. I understand that UMHC is committed to providing thehighest level of protection and safety to our patient. Photo identification is requested for all visits in an effort to detect, prevent, and mitigate any potential identity theft. I give my permission for photography and video monitoring/recording for purposes of clinical care, education and quality that are part of my clinical care. I am aware that for the safety and security of patients and guests, persons entering these facilities are being monitored and recorded by closed circuit television.

AUTHORIZATION FOR RELEASE OF INFORMATION

The UMHC and its staff who provide professional services to me are authorized to furnish requested information or excerpts from my medical record to the referring physician. The UMHC is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred, or to authorized family members, or to accrediting/regulatory organizations (for audit purposes).

PERSONAL VALUABLES

The UMHC will not be liable for any adverse occurrence to or for the loss, damage or theft of any patient's or visitor's property of any nature. The hospital maintains and provides a safe for deposit of any valuables.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, IS AT LEAST 18 YEARS OF AGE, OR HAS LEGAL AUTHORITY TO EXECUTE A CONTRACT, AND IS THE PATIENT,OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

I HAVE READ AND UNDERSTAND AND THE ABOVE (OR IF NECESSARY, HAD IT READ OR EXPLAINED TO ME), AND BY SIGNING AGREE TO ITS TERMS.

_____

Signature of Patient (Parent or Legal Guardian) *Relationship to Patient (if Representative)* *Date Signed*

Submit